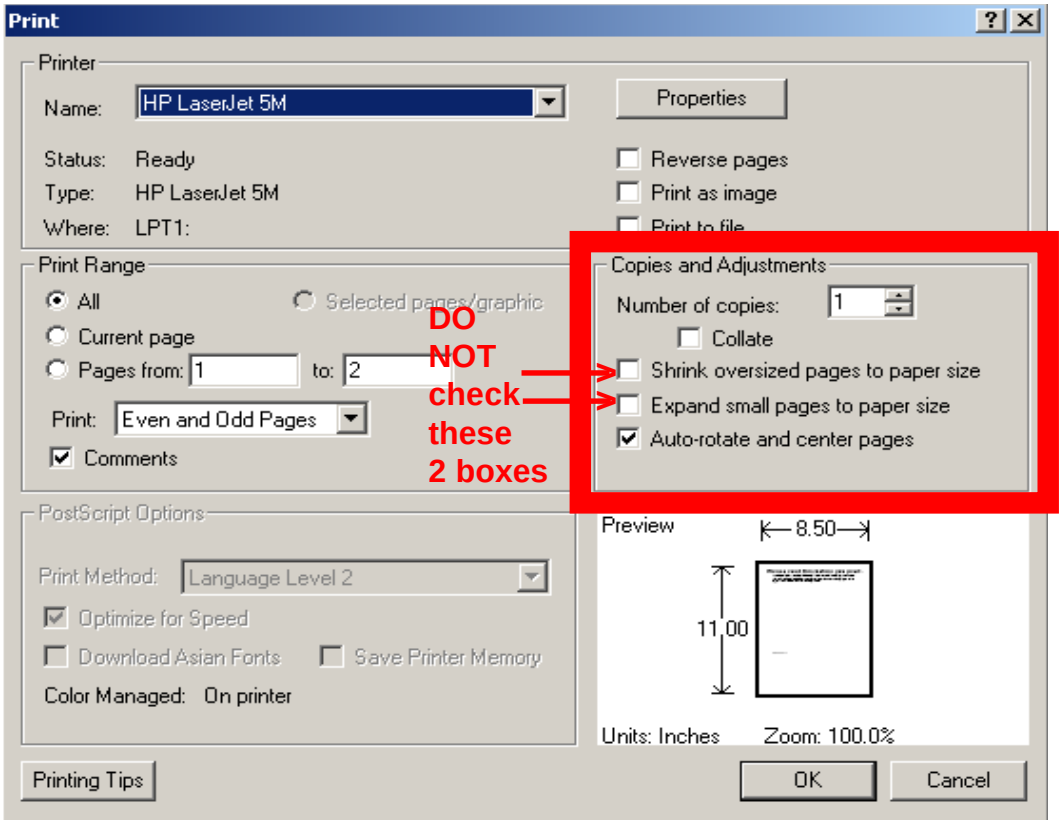
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Acupuncturist License Application Packet

1. 685-012 ... Contents List/SSN Information/Deposit Slip ..... 2 pages
2. 685-007 ... Application Instructions and Qualifications for Licensed Acupuncturist ..... 4 pages
3. 685-001 ... Application for Licensed Acupuncturist ..... 4 pages
4. 685-005 ... Education Completed ..... 1 page
5. 685-010 ... State Board Reference Form ..... 1 page
6. 685-011 ... Verification of Clinical Training in Acupuncture ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Acupuncturist

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 685-012 (REV 12/2002)

1F 0295010000 00356

Application Instructions And Qualifications For Licensed Acupuncturist

Note: Please refer to the enclosed law relating to Acupuncture (RCW 18.06) for additional information.

When your application for acupuncture licensure has been received by the Department of Health, you will be sent an acknowledgment letter noting any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check the status of an application until receipt of this acknowledgment letter. Your cooperation is needed to permit the program's staff to prepare your file and issue your license at the earliest possible time.

Applications and supporting documents are held for **one year only** from the date of receipt. Applicants who have not obtained licensure within two years of having made application to the Department of Health must reapply—including payment of non-refundable application fee(s).

Washington State Law and Department of Health policy prohibits employees from receiving any gifts, gratuities and/or favors. Any offer of private benefit to an employee that is intended to influence a public decision is bribery and violates Federal and State law. (RCW 42.18.320(2)).

If you have any questions, please call the Customer Service Center at (360) 236-4700.

Qualifications:

Any person seeking acupuncture licensure shall present proof of successful completion of didactic and clinical training courses which have been approved by the Secretary and which meet the following requirements:

A. Didactic Training—Basic Sciences and Acupuncture

1. Completed over a minimum period of (2) academic years.
2. 45 quarter credits or 450 hours of instruction in the following subjects.

   Anatomy
   Physiology
   Microbiology/Bacteriology
   Biochemistry
   Pathology
   Survey of Western Clinical Sciences
   Hygiene (minimum one credit) (included in Microbiology or Clean Needle Technique Course)
   Cardio-Pulmonary Resuscitation (CPR) (minimum one credit)

3. 75 quarter credits or 750 hours in acupuncture sciences including but not limited to the following subjects:

   Fundamental Principles of Acupuncture
   Acupuncture Diagnosis
   Acupuncture Pathology
   Acupuncture Therapeutics
   Acupuncture Meridians and Points
   Acupuncture Techniques, including electro-acupuncture

B. Clinical Training—Acupuncture

1. Includes a minimum of 9 quarter credits or 100 hours of observation, which shall include case presentation and discussion.
2. Supervised practice consists of at least 400 separate patient treatments involving a minimum of 100 patients. Twenty-nine quarter credits of supervised practice shall be completed over a minimum period of one academic year.
3. Patient treatment includes intake interview; traditional acupuncture examination and diagnosis; discussion between instructor and student concerning the proposed diagnosis and treatment plan; and applying acupuncture treatment principles and techniques. (A minimum of 360 patient treatments involving point location, insertion and withdrawal of all needles must be performed.)

Documentation Needed and Checklist to Ensure Submission of all Necessary Forms and Fees:

☐ **Completed application** (form enclosed), *including a current photograph*. Attach the photo to the front page of the application where indicated. Indicate date taken across the bottom of the photo. The photograph must be an original, not a photocopy, no larger than 2" x 2", taken within one year of application, close up front view. All four pages of the application must be completed. Enter the address where you wish subsequent information/renewal notices to be sent.

All Personal Data questions must be answered. If you respond "Yes" to any of the questions, submit a written statement in explanation of the circumstances, including dates, any treatment received, etc. You will be contacted if the need for further information has been determined.

☐ **$50.00 non-refundable application fee.** Make your check or money order payable to the Department of Health. Please mail the application and fee to:

Department of Health
Acupuncture Program
P. O. Box 1099
Olympia, WA 98507-1099

☐ **AIDS Education and Training Attestation within the application.** Before you can be licensed, you must attest on the application that you have completed seven hours of HIV/AIDS education as defined in WAC 246-12-270 of the attached lawbook. It is your responsibility to obtain course work that meets Washington requirements.

☐ **Official transcript.** The transcripts must be for all pre-acupuncture and acupuncture school/educational programs. They must be sent directly from your school to the Department of Health.

☐ **Verification of clinical training.** The clinical training form must be completed by the approved Acupuncture school verifying completion of your clinical training. The completed form must be sent directly from your school.

☐ **Education Completed (each course must be listed on form).** Must be completed and submitted with the application.

☐ **NCCAOM verification.** Request verification of passing the NCCAOM examinations. The verification is to be sent directly to the Department of Health. The portions of the exam must include the written exam, point location and clean needle technique course. The telephone number for NCCAOM in Alexandria, Virginia is (703) 548-9004.

Please Note: If the NCCAOM examinations were not passed in English, then you need to take the Test of English as a Foreign Language.

☐ **Verification of TOEFL.** You must have written verification of having passed the Test of English as a Foreign Language (TOEFL) with a minimum raw score of 550 sent directly to the Department of Health. If you wish to be scheduled for this examination or if you wish to have verification of your scores sent to this office, contact the TOEFL Registration Office at P. O. Box 6152, Princeton, NJ 08541-6152 or call (609) 951-1100. The "TOEFL code" for Washington State is **WA0201.**

☐ **Verification of licenses.** You will need to request all U.S. and foreign boards and jurisdictions where you have held a professional license to send verification of your license directly to the Department of Health. *Verifications will only be accepted if mailed to this office from the state board/jurisdiction office(s).* License copies are not acceptable in lieu of state/jurisdiction license verification.

☐ **CPR certification.** A copy of your unexpired Cardio-Pulmonary Resuscitation (CPR) card must be sent to this office.

Note: All required documents, except the application and fee, are to be sent to the following address:

Department of Health
Acupuncture Program
P. O. Box 47867
Olympia, WA 98504-7867

Renewal of License

The expiration of your license will be on your birthday. The first renewal will take place on your birthday within one year from date of issuance.

All subsequent renewals will be due every year on your birthday. A courtesy reminder will be mailed to you approximately 45 to 60 days prior to the expiration date of your license. For this reason, it is important to keep this office advised in writing of any address/name changes to ensure receipt of this notice. However, it is the responsibility of the licensee to maintain current status with the Deportment of Health.

Please allow 2 to 3 weeks from the date you mail your renewal notice, fee and updated Plan for Consultation, Emergency Transfer and Referral form to receive your updated license.

Send written address/name changes to the address listed above.

Approved Education

The Department shall consider for approval any school, program, apprenticeship, or tutorial instruction which meets the requirements outlined in chapter 18.06 RCW and which provides all or part of the courses required in RCW 18.06.050. These educational modes are defined, for purposes of administering the acupuncture statute and rules, as follows:

1. An Acupuncture School is a academic institution which has the sole purpose of offering training in acupuncture.
2. An Acupuncture Program is training in acupuncture offered by an academic institution which also offers training in other areas of study. A program is an established area of study offered on a continuing basis.
3. An Acupuncture Apprenticeship is training in acupuncture which is offered by a qualified acupuncture employer to an apprentice on the basis of an apprenticeship agreement between the employer and the apprentice. An apprenticeship is of limited duration and ceases at the time the parties to the apprenticeship agreement have performed their obligations under the agreement.
4. An Acupuncture Tutorial Instruction is training in acupuncture which is offered by an academic institution or qualified instructor on the basis of a tutorial agreement between the school or instructor and the student. Tutorial Instruction is of limited duration and ceases at the time the parties to the tutorial agreement have performed their obligations under the agreement.

Application for approval of a school, program, apprenticeship or tutorial instruction shall be made by the authorized representative of the school or the administrator of the apprenticeship or tutorial agreement.

A school or program may be approved by the secretary without formal application to the department provided that:

1. The school or program is an accredited United States post-secondary school or program.
2. The school or program is accredited under the procedures of another country and these procedures satisfy accreditation standards used for post-secondary education in the United States.
3. The non-accredited school or program is approved by or holds candidacy status with the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine.
4. The non-accredited school or program is approved by the Washington State Department of Health to prepare persons for the practice of acupuncture.

Applications for approval of all other schools, programs, apprenticeships or tutorial contracts may be submitted on a form provided by the department.

An applicant may request approval of the school, program, apprenticeship or tutorial instruction as of the date of the application or retroactively to a specified date.

The application for approval of a school, program, apprenticeship or tutorial instruction shall include documentation required by the department pertaining to educational administration, qualifications of instructors, didactic and/or clinical facilities and content of offered training.

An application fee of $500.00 must accompany the completed application.

Washington State Department of Health

Health Professions Quality Assurance Division
Acupuncture Program
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE #

LICENSE #

Application For Licensed Acupuncturist

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application Fee is Non-Refundable. Make Remittance Payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL** BUSINESS HOURS.)	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH
☐ Female ☐ Male	/ /	

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list full name(s)

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Previous Licensure

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. (Attach additional 8 1/2 x 11 sheet if necessary.)

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE	CURRENTLY IN FORCE
			YR ISSUED	NUMBER		
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

☐ I have never been licensed to practice Acupuncture in any jurisdiction.

3. Personal Data

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Pre-Acupuncture Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 x 11 sheet if necessary.)

FULL NAME, CITY AND STATE SCHOOLS ATTENDED	DEGREE EARNED	ATTENDANCE	
		ENTRANCE DATE	ENDING DATE

CERTIFIED ACUPUNCTURIST DIDACTIC PROGRAM			
ADDRESS			
CITY	STATE	ZIP	COUNTY

CERTIFIED ACUPUNCTURIST CLINIC PROGRAM			
ADDRESS			
CITY	STATE	ZIP	COUNTY

5. Professional Experience

In chronological order, list all professional experience. (Exclude activities listed under other sections.) (Attach additional 8 1/2 x 11 sheet if necessary.)

INDICATE NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	INCLUSIVE DATES OF EXPERIENCE	
	BEGINNING DATE	ENDING DATE

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

7. Plan For Consultation, Emergency Transfer And Referral

I certify that prior to establishing a place of practice, I will submit to the Department of Health my written consultation plan and have the plan on file at my place of business which shall include:

1. The name address and telephone numbers of two consulting physicians licensed under chapter 18.71 RCW or 18.57 RCW. The file shall include confirmations from the physicians as to their agreement to consult with and accept referred patients
2. The name, address and telephone number of the nearest emergency room facility.
3. As emergency transport mechanism (i.e., ambulance) with the name, address and telephone number of the dispatcher nearest the location of the practice.

I further understand that I shall consult with or refer patients to one of the consulting physicians if a potentially serious disorder as identified in WAC 246-802-110 is suspected.

Applicant's Initials	Date

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in this
Name of Applicant

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

Education Completed

This completed form is required of all applicants prior to a license being issued.
Please make copies if additional space is required.

Applicant Name _____

Western Science Courses (all courses taken from ANY school)

YEAR	NAME OF SCHOOL/PROGRAM	TITLE OF COURSE	EQUIVALENT TO THIS REQUIRED COURSE	CREDITS
**1994*	*University of Washington*	*Biology 102*	*Microbiology*	*3*

Acupuncture Education Completed

YEAR	NAME OF SCHOOL/PROGRAM	TITLE OF COURSE	EQUIVALENT TO THIS REQUIRED COURSE	CREDITS
**1997*	*Bastyr*	*Acupuncture Theory*	*Fundamental Principles of Acup.*	*5*

** Example*

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Health Professions Quality Assurance Division
Acupuncture Program
P.O. Box 47867
Olympia, WA 98504-7867

TO THE STATE BOARD: The individual below is applying for licensure as an Acupuncturist in Washington State. To assist the Acupuncture Program in their review, please complete the following information and return directly to the address located on the letterhead.

Thank you for your cooperation.

Name of Licensee: _____

License Number: _____ Date of Issue: _____

Expiration Date: _____

Issued on the Basis of: _____

State Examination: _____ National Board: _____

Reciprocity/Endorsement from (indicate state): _____

Other (explain): _____

_____

Has licensee's license ever been suspended, revoked or subject to other disciplinary action?

☐ Yes ☐ No

If yes, please explain: _____

_____

S
E
A
L

_____
SIGNATURE OF VERIFIER

_____
TITLE

_____
STATE BOARD

_____
DATE

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Health Professions Quality Assurance Division
Acupuncture Program
P.O. Box 47867
Olympia, WA 98504-7867

Verification Of Clinical Training In Acupuncture

Applicant's Name: _____ DOB: _____

Clinical Training Received: _____
(Name of School or Clinic)

_____
(Address of School or Clinic)

Dates of Training: From: _____ To: _____

This is to certify that the above named applicant has completed clinical training consisting of the following:

1. Number of patient treatments: _____

2. Number of patients treated: _____

3. Number of patient treatments involving the insertion/withdrawal of needles: _____

4. Minimum number of patient treatments per academic quarter: _____

_____
(Signature of School or Clinic Instructor)

Subscribed and sworn to before me this _____ day of _____ 20_____.

Notary public for the state of _____ residing at _____.

S E A L

_____
(Notary Signature)